Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 12, 2018	2018_745690_0008	005834-18	Resident Quality Inspection

Licensee/Titulaire de permis

Board of Management for the District of Parry Sound West
21 Belvedere Avenue PARRY SOUND ON P2A 2A2

Long-Term Care Home/Foyer de soins de longue durée

Belvedere Heights
21 Belvedere Avenue PARRY SOUND ON P2A 2A2

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

TRACY MUCHMAKER (690), MICHELLE BERARDI (679), TIFFANY BOUCHER (543)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): August 7-10 and 13-17, 2018

The following critical incident (CI) reports were inspected during this Resident Quality Inspection (RQI):
-One that was related to a respiratory outbreak;
-One that was related to alleged resident to resident physical abuse;
-One that was related to alleged staff to resident physical abuse;
-Three that were related to falls, which resulted in a change in the resident's condition.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Director of Nursing Administration (DONA), Nutrition Manager (NM), Program Manager (PM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents and Family Members.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, as well as numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **9 WN(s)**
- **6 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan of care had not been effective.

Inspector #679 reviewed a CI report submitted to the Director for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the residents' health status. The CI report identified that resident #005 fell, resulting in an injury.

Inspector #679 reviewed the resident's electronic progress notes and identified that the resident experienced a number of falls in the quarter before the fall.

Inspector #679 reviewed the electronic care plan and could not identify changes made to the resident's interventions in the quarter before the fall.

Inspector #679 reviewed the home's policy entitled "Falls Prevention & Management Policy: NR G 535" last revised July 2014, which identified that staff were to monitor and evaluate the care plan at least quarterly in collaboration with the interdisciplinary team. The policy further identified that if the interventions had not been effective in reducing falls registered staff were to initiate alternative approaches and update as necessary.

In an interview with PSW #122 they identified that interventions regarding a residents fall interventions would be located in the plan of care. PSW #122 identified if interventions in the plan of care weren't effective for preventing falls then new interventions would be implemented.

In an interview with RPN #123 they identified that interventions for fall prevention were updated at least quarterly. RPN #123 identified that if a resident was experiencing a number of falls, then the fall prevention interventions should be re-evaluated.

In an interview with the DONA they identified that care plans were to be updated when interventions were not effective, quarterly and at the time of each fall. The DONA identified that they had reviewed the care plan at the time of the CI report and noted that the interventions had not been changed. The DONA acknowledged that the interventions were not effective in preventing falls, and that the care plan had required updating. [s. 6. (10) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are reassessed and the plan of care is reviewed and revised at least every six months and at any other time when the care set out in the plan of care has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy promoting zero tolerance of abuse and neglect of residents was complied with.

Inspector #679 reviewed a CI report submitted to the Director for incidents of improper /incompetent treatment of a resident that resulted in harm or risk of harm to a resident. The CI report identified that the incident happened on an identified date, and that it was reported to the Director four days later.

A review of the CI report identified that on an identified date, Personal Support Worker (PSW) #107 allegedly witnessed PSW #106 physically abuse resident #003. A review of the CI report also identified that resident #004 reported to PSW #107 and #103 that PSW #106 allegedly abused them while providing care causing an injury. The CI report identified that PSW #107 emailed the concerns to the Director of Nursing and Administration (DONA) later that day.

Inspector #679 reviewed the home's internal investigation and identified an email on an

identified date from PSW #107 to the DONA. The email identified that PSW #106 allegedly abused resident #003. The email further identified that "last week" resident #004 told PSW #107 and #103 that PSW #106 had allegedly abused them while providing care causing an injury.

Inspector #679 reviewed the policy entitled "Prevention of Abuse and Neglect ZERO Tolerance (PER- 2300)" effective August 2018. The policy identified the following under the "procedure to be followed by all staff and volunteers in the event of alleged, witnessed or suspected abuse/neglect": immediately inform the Registered Nurse (RN) or the DONA of the situation. The policy further stated that it was a requirement for a person who had reasonable grounds to suspect that a resident had suffered or may suffer abuse to report the suspicion and the information on which it was based to the RN/DONA, CEO or manager on call immediately.

In an interview with resident #004 they identified that there was an incident in which PSW #106 was rough while providing them care.

In an interview with PSW #107 they identified that PSW #106 had performed a specified action towards resident #003 causing them to yell out. PSW #107 further identified that resident #004 had reported to them that PSW #106 was rough while providing care causing an injury. PSW #107 identified that allegations of abuse or neglect should be reported to the Registered Practical Nurse (RPN) right away, and that they had sent an email to the DONA about the incident.

In an interview with the DONA they identified that allegations of abuse or neglect were to be reported immediately. The DONA identified that they received the email outlining the allegations on a specified date, and that the staff should have reported this to the registered staff who would then report to the manager on call.

In summary, the licensee has failed to ensure that the policy promoting zero tolerance for abuse or neglect was complied with; specifically, the staff involved failed to follow the proper reporting procedures, and, provided rough care to two specified residents. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the policy promoting zero tolerance of abuse and neglect is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #017 was identified as having new areas of altered skin integrity from their previous to most recent Minimum Data Set (MDS) assessment.

Inspector #543 reviewed resident #017's wound care assessments which identified, areas of altered skin integrity, on their wound care assessment on a specified date.

There were no further wound care assessments completed for the identified areas of altered skin integrity.

The Inspector reviewed the home's "Skin and Wound Management Program" (NR G 515) effective date of May 2018. This policy identified that any resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received an assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument specifically designed for skin and wound assessment. The registered nursing staff would complete the Goldcare AIM Wound Assessment (weekly as above) including size, circumference and depth of the wound, discharge if present, appearance, progression, pain and equipment being used, etc.

Inspector #543 interviewed RPN #109 who verified that wound care assessments are to be completed on a weekly basis for resident #017.

Inspector #543 interviewed RPN #112 who indicated that wound care assessments are to be completed at least on a weekly basis and more often if necessary for resident #017.

Inspector #543 interviewed the DONA, who indicated that wound care assessments are completed on admission, readmission, and quarterly. If there are any areas of altered skin integrity or potential for altered skin integrity, there should be a wound assessment done, including any relevant referrals. The DONA indicated that any wound, altered skin or potential for altered skin integrity are to be reassessed weekly and as necessary. The DONA verified that there were no wound care assessments completed for the wounds after a specified assessment. [s. 50. (2) (b) (iv)]

2. Resident #016 was identified as having worsening areas of altered skin integrity from their previous to most recent MDS assessment.

Inspector #543 reviewed resident #016’s wound care assessments which identified, areas of altered skin integrity, on their wound care assessment on a specified date. There were no further wound care assessments completed until a specified date six weeks later.

Inspector #543 interviewed RPN #109 who verified that wound care assessments were to be completed on a weekly basis. The RPN indicated that they could not say for sure why no further assessments or progress notes were completed until a specified date six

weeks later.

Inspector #543 interviewed RPN #112 who indicated that wound care assessments were to be completed at least on a weekly basis and more often if necessary.

Inspector #543 interviewed the DONA, who indicated that wound care assessments are completed on admission, readmission, and quarterly. If there are any areas of altered skin integrity or potential for altered skin integrity, there should be a wound assessment done, including any relevant referrals. The DONA indicated that any wound, areas of altered skin or potential for altered skin integrity are to be reassessed weekly and as necessary. The DONA verified that there were no wound care assessments completed between a six week period. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences.

Inspector #543 reviewed the home's "Prevention of Abuse and Neglect Zero Tolerance" (PER-2300) policy effective as of August 2018. The policy indicated that the policy would be evaluated and updated annually, to determine the effectiveness of this policy.

Inspector #679 requested to review the home's 2017 abuse program evaluation and in an interview with Inspector #679, the Chief Executive Officer (CEO) verified that the home's "Prevention of Abuse and Neglect Zero Tolerance" (PER-2300) policy was not evaluated in 2017. [s. 99. (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents and what changes and improvements are required to prevent further occurrences, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Inspector #679 reviewed the home's medication incident reports, and identified the following three medication errors:
- The scheduled dose of a specified medication was not administered to resident #005 as prescribed;
- One scheduled dose of a specified medication was not administered to resident #020 as prescribed; and,
- The scheduled dose of a specified medication was not administered to resident #019

Inspector #679 reviewed the homes policy entitled "Medication Pass" last reviewed Jan 17, 2017, which identified that the eight rights of medications must be observed when administering medications to a resident to reduce medication errors. The policy identified that the nurse is responsible for ensuring the right client, medication, time and frequency.

In an interview with RPN #123 they identified that staff utilize an electronic medication administration record (eMar) to complete a medication administration. RPN #123 confirmed that it was the expectation of the home that medications were administered to residents in accordance with the directions for use specified by the prescriber.

In an interview with the DONA they confirmed that it was the expectation of the home that medications were administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's substitute decision maker (SDM), if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident.

Inspector #679 reviewed the home's medication incident reports, and identified the following three medication errors:

- The scheduled dose of a specified medication was not administered to resident #005 as prescribed;
- One scheduled dose of a specified medication was not administered to resident #020 as prescribed; and,
- The scheduled dose of a specified medication was not administered to resident #019

A further review of the medication incident reports identified that the section to indicate whether the physician, resident or family was notified was blank on all three forms. Inspector #679 conducted a review of Gold Care, and was unable to identify any progress notes to indicate that the physician or the family were made aware of the incident.

In an interview with RPN #114 they identified that when staff discover a medication error it would be reported to the supervisor and that a medication incident report would be filled out. RPN #114 identified that it would depend on the type of medication error to determine if the family or physician was notified. RPN #113 identified that the notification would be documented on Gold Care.

In an interview with the DONA, they identified that the physician and the SDM should be notified of any medication errors that reach a resident. Inspector #679 and the DONA reviewed the medication incident reports, and the DONA identified that the physician and the SDM should have been notified. The DONA identified if there were no progress notes then the SDM and the physician were likely not notified. [s. 135. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every mediation incident involving a resident and every adverse drug reaction is reported to the resident, the resident's substitute decision maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or registered nurse in the extended class attending the resident, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that the following had occurred or may occur immediately reported the suspicion and the information upon which it was based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

During an interview with Inspector #679, resident #001 identified that a staff member had yelled at them on a specified date. Resident #001 identified they didn't know what they had done wrong, or what the staff member was yelling at them for.

On August 8, 2018, Inspector #679 brought the concern forward to the homes CEO.

A Critical Incident (CI) report was submitted to the Director for the alleged incident of abuse the following day.

Inspector #679 reviewed the policy entitled "Prevention of Abuse and Neglect ZERO Tolerance (PER- 2300)" effective August 2018. The policy identified that a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. The policy further identified that the DONA or designate will immediately initiate the on line mandatory CI system, or after – hours reporting line.

In an interview with the DONA, they acknowledged that the CI report was submitted the following day. The DONA identified that allegations of abuse or neglect were to be reported immediately. [s. 24. (1)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written response was provided to the Resident's Council within 10 days of receiving concerns or recommendations.

Inspector #679 reviewed the Resident Council meeting minutes dated June 26, 2018. The meeting minutes identified the following statement "Concern about the inconsistency of the meals beginning on time". Inspector #679 reviewed the Resident Council minute binder, and was unable to locate a written response.

In an interview with Inspector #679, resident #018, who was the President of the Resident's council could not recall if the Resident's Council received a written response from the home related to the concern about the inconsistency of the meals beginning on time.

In an interview with Inspector #679, the Programs Manager (PM), identified that this issue required meetings with all managers to identify a solution. The PM identified that the home did not use the 10 day response form to respond to this concern, that they provided a verbal update to resident #018 and that the follow up with the resident council would occur at the September meeting. [s. 57. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

On August 7, 2018, Inspector #679 conducted the initial tour of the home and identified that a specified resident room in the home had an isolation cart, but there was no signage identifying the type of isolation required.

Inspector #679 reviewed the health care record for the resident that resided in the specified room, under the others alert tab and identified the resident had a specified infection.

Inspector #543 reviewed the home's Protocol-Interventions for the Prevention and Control policy for the specified infection. The policy indicated that contact precautions would be initiated whenever admitting a resident with the infection specified in the policy, and a "Contact Precaution" sign would be placed on the resident's room door.

Inspector #679 interviewed PSW #113 who indicated that the resident that resided in the specified room was not on any isolation precautions.

Inspector #679 interviewed RPN #112 who verified that the resident that resided in the specified room was on isolation precautions, and typically signage is posted on the room door.

The Inspector interviewed the DONA who verified that the resident's room should have signage up indicating the type of isolation precautions required. [s. 229. (4)]

Issued on this 13th day of September, 2018

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.